Personalised Care and Support Planning Implementation Guidance

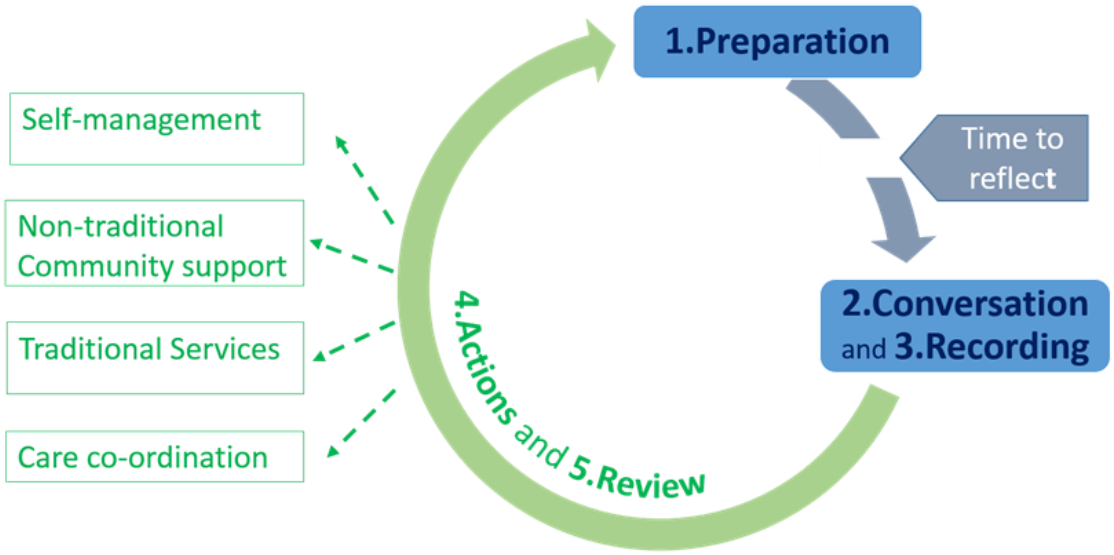
Personalised care and support planning (PCSP) is a way of providing care to people with single and multiple long-term conditions (LTCs), including frailty, that aims to ensure people get more out of their brief contact with the health care system.

The approach was developed by Year of Care Partnerships® and the process begins with an information gathering appointment in which tasks and tests are completed ahead of the PCSP conversation appointment. The results of any information gathered, together with reflective prompts, are sent to the person 1-2 weeks before the PCSP conversation (this is called preparation).

The PCSP conversation has a solution focussed and forward-looking approach which acknowledges the experience and expertise of the patient and brings together traditional clinical issues with what is most important to the individual, supporting self-management, coordinating complex care and signposting to social prescribing.

It is an enabling conversation, focusing on what matters to the person, which produces a plan of self-care for the individual to support them in their day to day decisions over the next few months. The aim is to enable people to live well and manage their LTCs. This encompasses both biomedical and psychosocial elements of care.

Personalised care and support planning components



Implementing personalised care and support planning

Implementing PCSP doesn't happen by chance and is best achieved in **three stages - set up, initial implementation and maintenance**. This is usually supported by a local steering group which takes on the role of active local leadership, coordination and providing solutions to local delivery issues. This document summarises the activities that need to be considered across these stages and the support that can be provided by Year of Care including advice, training and facilitation via direct support to practices and practical resources.

Stage 1: Set up

It is helpful to consider how PCSP planning fits into local strategy in terms of LTC care/personalised care and setting this out as a regional/local objective can ensure adequate support. The following activities are typically needed for the successful implementation of PCSP.

a. Set up a steering group

Setting up a local steering group to oversee the implementation of PCSP is usually crucial to successful delivery and embedding of the approach. It is suggested the following roles are assigned to individuals:

- Local clinical 'champions'
- Clinicians/admin leads who can deliver on elements of development decided on by the steering group
- Admin/coordination of programme (programme management role)
- Support to develop IT and administrative processes
- More than medicine link – third sector and community activities and/or service user involvement

In general, people involved with this programme should **embrace the ethos of personalised care**. It is important for them to be able to articulate what PCSP is, and how it differs from previous ways of working (training will help with this).

The main activities of the steering group are to ensure momentum behind implementation and roll-out and the required infrastructure is in place, including removing disincentives or barriers. You may need to consider the following operational issues and activities:

- Benefits and the aims of implementing PCSP (personalised care, more streamlined care, improving patient involvement in care, improving care processes, better links to third sector organisations and activities)
- How will you evaluate impact once the programme is up and running (how will you know it's happening and that it is having the anticipated benefits)?
- Support for practices versus incentive schemes
- Areas to focus on:
    - Who will be involved in the steering group - roles and responsibilities
    - Engagement of clinical teams
    - Identifying early adopter practices and clinical champions
    - How different ways of working are going to be supported such as local enhanced services, creating headspace for clinical teams/in-practice steering groups
    - How clinicians are going to be supported to attend Year of Care training
    - Facilitation and support to individual practice teams
    - The role of IT and how individual practices gain support with their clinical systems
    - Further training requirements for healthcare assistants, practice nurses and administrative teams
    - Social prescribing and more than medicine

b. Identify the group of patients for initial focus (e.g. single condition or multiple long-term conditions)

It is important to give clinical teams some control over how they implement the programme in practice to ensure local ownership. This might be influenced by need such as improving outcomes in some groups, focusing on coordinating care or neglected groups, or national/local incentive schemes. Typically localities choose to work with one of these groups of patients:

- Individuals with a single condition such as diabetes or COPD
- Those living with multiple LTCs and/or frailty and complex needs

You will need to find a **method of identifying these individuals, review numbers of people expected to be invited and devise a recall system**.

If you choose too small a group of patients it may feel like a lot of work to change the systems of care for a relatively small benefit and, in practice, dual running of different types of reviews can be administratively difficult and give insufficient exposure to new ways of working for clinical staff.

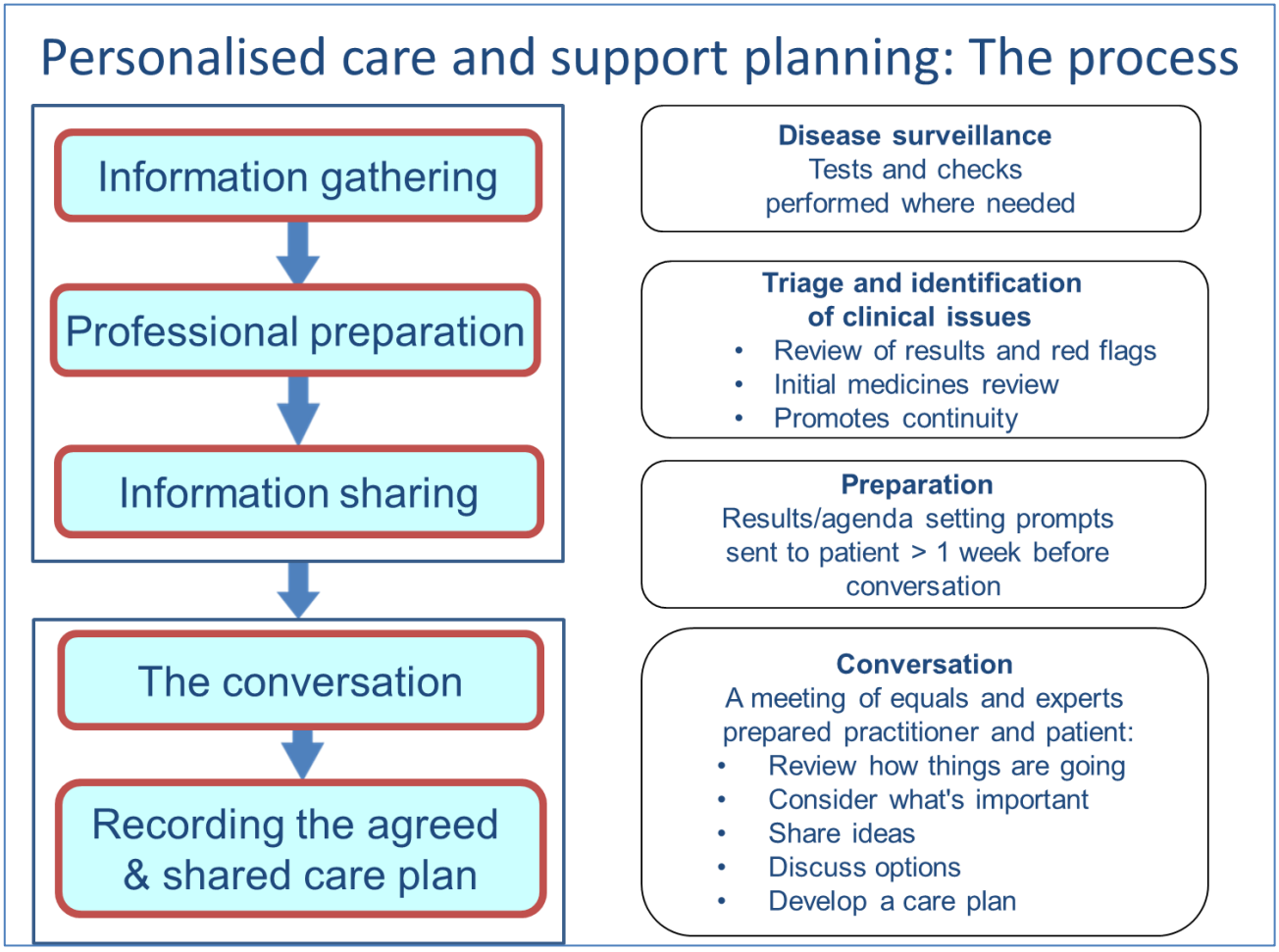
c. Define the local 'model of care'

This next preparatory step involves describing where PCSP will take place and which practitioners and teams will be involved, described as the local 'model of care'.

For the majority of people living with LTCs, including those who are living with frailty, routine PCSP will take place in primary care, usually by general practice or multidisciplinary community teams linked with them.

The process is described in the following diagram and the steering group should **consider how this will work locally**. This includes topics such as how triage will work and creating continuity for the patient.

Alongside our Personalised Care Institute accredited training, Year of Care has developed a package of facilitation, tools and resources to support the PCSP process.



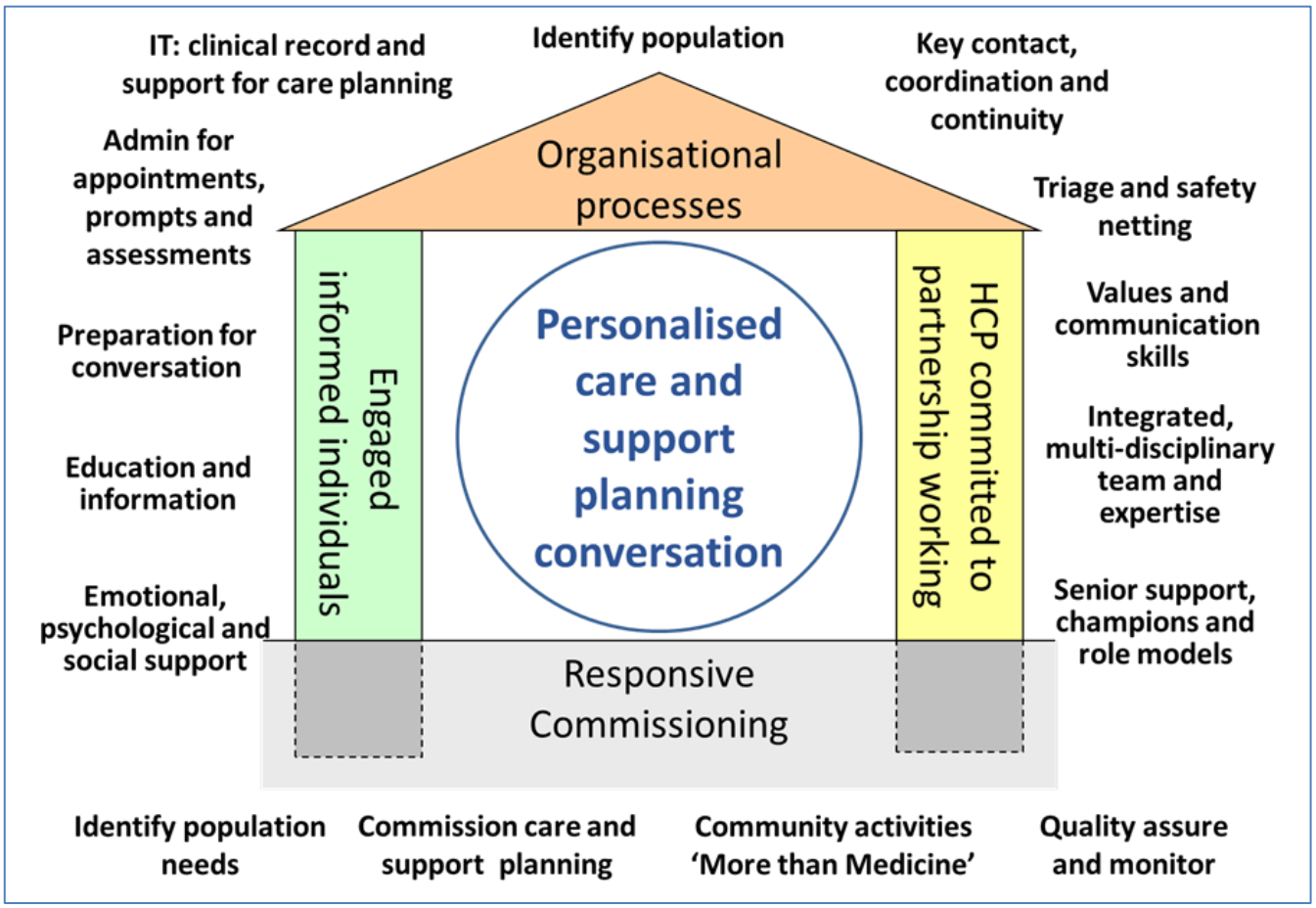
Stage 2: Implementation and training

This stage is about **introducing and embedding PCSP**, and 'more than medicine' activities into local practice using the Year of Care house framework. This includes:

- Engaging care professionals – benefits to practices and a common understanding of the purpose and value of PCSP (Year of Care introductory session/clinical leadership)
- Delivering Year of Care training and facilitation to practice teams
- Developing and supporting exemplar practices – sharing learning and removing barriers
- Ensuring that the various components of the Year of Care house are in place
- Practices will need to consider how PCSP will work in their practice including how the information gathering and PCSP conversation appointments will work - this includes appointment length, responsibilities of team members, how appointments are booked and whether they are remote or face to face
- There will also need to be an opportunity for review and reflection to consider how things are going, how you can make it work better and how the scope of PCSP can be increased at the right time

The Year of Care House

The Year of Care house describes what needs to be in place to deliver PCSP and can be used a checklist for implementation activities.



Left wall of the Year of Care House: Engaged and informed individuals

When PCSP is first introduced it's important to ensure that everyone involved understands this new way of working and their role within it, including patients.

- **Information to prepare patients for the change in system/process** should be written in an appropriate, clear style. This includes but is not limited to:
  - posters for waiting rooms
  - flyers and leaflets
  - information on websites
  - practice TV screens
  - a 'script' describing PCSP for receptionists / healthcare assistants and volunteers

As part of the Year of Care programme practices will be provided with a pack of information and resources that includes the patient and practice materials mentioned above alongside example of results letters, checklists and self-reflection tools.

- It's important to think about **what you are going to call the new model of care** so that all staff can use the term consistently, and people with LTCs understand what it means.
- To **prepare for the consultation** information such as explanatory material with agenda setting prompts and tests results (where appropriate) will be shared with the patient and practices should begin to consider how this will work and who will be involved. This material will need to be locally configured to ensure it fits with local guidelines and the groups of patients you are inviting.

Right wall of the Year of Care House: Health care professionals committed to partnership working

The right wall describes two types of partnership working; working collaboratively with people living with LTCs as part of the PCSP process, and working in partnership with health and social care colleagues as members of multidisciplinary teams. Year of Care supports this in the following ways:

- **Clinical engagement** usually involves some Year of Care 'taster' or introductory' events for the local community to discuss the principles, promote the benefits and engage the early adopters/local exemplars.
- **Workforce development including training in PCSP -** Year of Care training and facilitation is important in addressing mindset (and roles) and builds on skills actively supporting those that will be part of the PCSP process to work in partnership with people with LTCs. It supports teams to work out the practical steps to put PCSP in place in their own practice or clinical setting. This includes checking that all components of the house are in place for everyone.
- Practices should ensure that all team members have the appropriate **skills, resources and training** including GPs, nurses, AHPs, health care assistants, practice managers and admin teams.
- There may also be a need for clinical training for health care assistants or clinical skills training for nursing staff who may be moving to a more generalist role, or becoming involved in PCSP for different conditions.

The roof of the Year of Care House: Organisational processes

Getting the **administration and organisational processes** in place to support PCSP is often a key task for the practice team working closely with the steering group. For example:

- IT templates will need to be developed (or shared from other areas) to support **information gathering** at the first appointment to collect all of the information needed for the PCSP conversation and to populate/mail merge into the patient preparation materials. This usually requires some local expertise in IT however commercial products are also available.
- Triage of results and inclusion of medicines review.
- Organising recall and allocating sufficient time to each appointment.

- Patient preparation materials (agenda setting prompts/routine test results) are shared at least a week before the PCSP conversation.
- Part of the Year of Care training programme is a facilitation session which involves supporting practices to work through how all the steps of PCSP will work in practice using a process mapping approach and develop a practice action plan.

The floor of the Year of Care House: Responsive commissioning (activities across the locality including more than medicine)

- Development of a **'more than medicine'** approach will require the identification of services and resources that support individuals to develop skills and offer supportive self-management; establishing a way for clinical teams to easily access these resources is an essential component of PCSP.
- Identifying unmet need and reallocating resources where needed to meet those needs.
- Monitoring and evaluation – including patient feedback.

Stage 3: Maintenance and sustainability

Maintaining new habits and ways of working is hard. Facilitation is important for practice development and will also identify where problems with practice processes are holding up the quality of PCSP, and where additional support is needed. The steering group may wish to think about some of the following ideas:

- Is PCSP actually happening – ensure fidelity
- There is on-going support for practices e.g. training for new staff members
- Do you need to train local trainers or facilitators?
- Opportunities are provided for the practitioner to reflect, share learning and develop
- Further skills training is identified
- Metrics and patient feedback are gathered, reviewed and fed back
- Supporting work to extend the scale or scope of PCSP following initial implementation
- Updating clinical aspects of templates etc as guidelines change